WIC PROGRAM
MEDICAL INFORMATION FORM FOR PEDIATRIC PROVIDERS

WIC ID#

Note to Health Care Provider:

Please print out this form, complete it and give it back to the child's family to return to WIC.

PATIENT INFORMATION

Patient Name:
Date of Birth:
Parent/Gaurdian Name:

ALL INFANTS/CHILDREN

Date Collected / /	Date Collected / /
Weight	Hgb
Length/Height	Hct
	Blood Lead
# DtaP immunizations given to date	

INFANTS/CHILDREN < AGE 2

Birth Weight
Birth Length
Gestational age at birth: _____ weeks

HEALTH/MEDICAL CONCERNS and RISK FACTORS

PATIENT'S HEALTH CARE PROVIDER

Provider Name	
Signature	Date / /
Address	Phone ( ) -